# PRIOR APPROVAL FOR MEDICAL SERVICES *

MAIL COMPLETED FORMS TO:
GHP
P.O. BOX 7000
McRAE, GEORGIA 31055

*Please provide written answer or check appropriate box. Type or print legibly. Where additional space is needed, please attach Supplemental Sheet.*

| 1. PHYSICIAN'S NAME OR AGENCY NAME | 2. PROVIDER # | 3. ☐ M.D. ☐ D.O. ☐ D.P.M. |
|---|---|---|
| ADDRESS | TELEPHONE | |
| 4. MEMBER'S NAME | 5. MEMBER ID NUMBER | 6. SEX |
| 7. ADDRESS | 8. DATE OF BIRTH | |

9. HOSPITAL

10. DIAGNOSIS

| 11. DATE MEMBER FIRST SEEN FOR ABOVE DIAGNOSIS | 12. MOST RECENT VISIT |
|---|---|

13. MEMBER'S PRESENT MEDICAL STATUS

14. TREATMENT OR SERVICES RENDERED

15. DATE AND RESULTS OF LAB PROCEDURES AND/OR X-RAYS

| 16. OPERATION, PROCEDURE, TREATMENT, OR SERVICE FOR APPROVAL Description | | Procedure/ Code | Estimated Price Per Unit | Units Of Service |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |

17. PLAN OF CARE

18. JUSTIFICATION FOR REQUESTING # 16.

| 19. **PHYSICIAN'S SIGNATURE** | 20. DATE SIGNED |
|---|---|
| DATE | SIGNATURE |

** Prior approval applies only to this member unless otherwise specified. The approval applies only if the member is eligible at the time the services are rendered.*

*** This request is subject to Retrospective Peer Review.*

DMA-81 (3/03)